MEDPAC Medicare Payment Advisory Commission

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M+C payment rates compared with county Medicare per capita fee-for-service spending

The purpose of this report is to present data on the level of Medicare+Choice (M+C) payment rates relative to the spending on similar beneficiaries in Medicare's traditional fee-for-service program.

Prior to the Balanced Budget Act of 1997 (BBA), payment rates for risk-based managed care plans were set at 95 percent of a county's per beneficiary spending under the traditional fee-for-service (FFS) program. The BBA instituted a new method for calculating payment rates that broke the direct link to county-level fee-for-service spending. Now, under current law, rates are the highest of absolute floors, a minimum guaranteed increase (2 percent) from prior year county rates or a blend of local and national rates. Those rates are updated using the rate of increase in national fee-for-service spending.

By design, the current payment formula lets county rates diverge from the average per beneficiary spending levels under the traditional program. For 2004, CMS projects that M+C payment rates will be higher than average FFS spending in about three-fourths (74 percent) of all counties. We find that about two-thirds (67 percent) of all Medicare beneficiaries and about two-thirds (66 percent) of M+C enrollees live in counties where the M+C payment rates would exceed average Medicare FFS spending in 2004. Table 1 illustrates the distribution of counties, Medicare beneficiaries, and M+C enrollees by the ratio of M+C payment rates to average Medicare FFS spending.

Table 1. Distribution of counties, Medicare beneficiaries, and M+C enrollees by the relationship between M+C payment rates and fee-for-service spending, 2004

Ratio of M+C rates to county per beneficiary FFS spending	Counties	Medicare beneficiaries	M+C enrollees
Total	100%	100%	100%
90% and below	8	9	6
90-95	8	11	14
95-100	10	13	14
100-105	12	19	27
105-120	34	31	28
120 and above	29	16	11

Note: M+C (Medicare+Choice), FFS (fee-for-service). Totals may not sum to 100 due to rounding.

Source: MedPAC analysis of payment and county spending data from CMS.

Across all counties, Medicare is paying M+C plans an average of 103 percent of what it would cost to cover the current mix of M+C enrollees under the traditional fee-for-service Medicare program. This estimate (along with all the other estimates in this report) assumes that the average health risk of the M+C and traditional enrollees are the same, other than those differences accounted for by demographic characteristics. If, as CMS has found, M+C plans enroll a less costly population than would be accounted for by demographics, Medicare would be paying M+C plans more than 103 percent of Medicare's spending under FFS.

There are several reasons why the payment rate for a county might exceed Medicare's average fee-for-service spending in the county. First, the payment formula's absolute floors are set

higher than FFS spending in many counties. Note that there are two floors that vary with the characteristics of a county. One floor applies to large-urban areas, defined as metropolitan statistical areas containing more than 250,000 residents. The other floor applies to all other counties. Table 2 shows that Medicare pays 110 percent of FFS spending for enrollees in floor counties in large urban areas and 113 percent of FFS spending in floor counties in other areas. By contrast, in non-floor counties Medicare pays 100 percent of average FFS spending.

Table 2. Distribution of Medicare beneficiaries and M+C enrollees and the ratio of M+C payment rates to fee-for-service spending, by county characteristics, 2004

County characteristics	Medicare beneficiaries	M+C enrollees	Ratio of M+C rates to county per beneficiary FFS spending
Total	100%	100%	103%
Floor status			
Non-floor	45	61	100
Large urban floor	32	36	110
Other floor	23	3	113
Urban	77	97	103
Rural	23	3	107
GME as share of FFS spending			
Low	28	20	97
Average	45	49	104
High	27	32	106

Note: M+C (Medicare+Choice), FFS (fee-for-service), GME (graduate medical education). The large urban floor applies to counties within metropolitan areas with more than 250,000 residents. The other floor applies to all other counties. Totals within county categories may not sum to 100 due to rounding.

Source: MedPAC analysis of payment and county spending data from CMS.

Second, the minimum 2 percent update component of the rate formula prevents county rates from declining, even if other portions of the formula would otherwise cause rates to decline. A good example of this occurs for counties with relatively high FFS hospital payments for graduate medical education (GME). Before the BBA, GME costs were included in the calculation of average FFS spending. The BBA removed (after a phase-in) GME costs from the calculation, and Medicare now pays teaching hospitals directly for GME for M+C enrollees. In many counties, the 2 percent minimum update requirement has prevented rates from falling to account for the removal of the GME costs. Table 2 shows that as the proportion of FFS spending in a county accounted for by GME payments increases, Medicare's M+C payments relative to FFS costs increase, ranging from 97 percent of FFS for counties with a relatively small proportion of GME spending to 106 percent of FFS for counties with relatively high proportions of spending devoted to GME.

In many counties, payment rates are below average FFS spending. This situation tends to occur when spending growth in the Medicare FFS program in the county has been more rapid than the national average since 1997, the county spending is above the floor levels, and GME payments are a relatively low share of FFS spending in the county.

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